Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

CALCIMIMETIC AGENTS PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: ☐ **Drug dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug administered in an office or outpatient setting (medical benefit)**

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:
1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests.
2. Complete **Section III** for **medication-specific safety criteria** if applicable to the medication requested.
3. Complete **Section IV** if this request is a **renewal**.
4. Complete **Section V** if the requested medication is also a **non-preferred medication** on the Kansas Medicaid PDL.
5. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:
□ Sensipar® (cinacalcet)
□ Parsabiv® (etelcalcetide)

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? □ YES □ NO

Indication: _____

ICD-10: _____

PATIENT NAME:		MEDICAID ID:	

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. **Is this a new or renewal request for this medication?**
   - □ New
   - □ Renewal – Proceed to section IV.

2. **Please list all medications the patient has previously tried and failed for treatment of this diagnosis.**

*Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance) and dates of previous trial.

Medication name	Reason for Discontinuation	Dates of trial

3. **Provide chart notes documenting the patient's clinical assessment and history of all prior therapy trials including dates and outcomes of trials.** □ YES □ NO

SECTION III: MEDICATION-SPECIFIC SAFETY CRITERIA

Select the requested medication from the list below and complete the medication-specific safety criteria questions that follow. If the medication for this request is not listed below, skip section III.

□ **SENSIPAR** for treatment of secondary hyperparathyroidism –
Does the prescriber attest to each of the following criteria? □ YES □ NO
1. Patient is on dialysis (hemodialysis or peritoneal dialysis).
2. Current serum calcium is ≥ 8.4 mg/dL.
3. Current iPTH (intact parathyroid hormone) levels are ≥ 300 pg/mL.

□ **SENSIPAR** for treatment of hypercalcemia in patients with parathyroid cancer –
Does the prescriber attest to each of the following criteria? □ YES □ NO
1. Current serum calcium ≥ 10.2 mg/dL.

□ **SENSIPAR** for treatment of primary hyperparathyroidism with severe hypercalcemia –
Does the prescriber attest to each of the following criteria? □ YES □ NO
1. Patient is unable to undergo parathyroidectomy.
2. Current serum calcium ≥ 12.5 mg/dL.

□ **PARSABIV** –
Does the prescriber attest to each of the following criteria? □ YES □ NO
1. Patient is on dialysis (hemodialysis or peritoneal dialysis).
2. Current serum calcium is ≥ 8.4 mg/dL
3. Current iPTH (intact parathyroid hormone) levels are ≥ 300 pg/mL.

SECTION IV: RENEWAL

1. **Is the patient on dialysis?** □ YES □ NO
   A. If Yes, which type? □ Hemodialysis □ Peritoneal dialysis

2. **Is the current serum calcium ≥ 7.5 mg/dL?** □ YES □ NO

3. **Is the current iPTH levels ≥ 150 pg/mL?** □ YES □ NO

PATIENT NAME:		MEDICAID ID:	

SECTION V: NON-PREFERRED MEDICATION

1. **Is the medication requested a non-preferred medication on the Kansas Medicaid preferred drug list (PDL)?** □ YES □ NO

   A. **If <u>YES</u>: Does the patient have a documented clinical rationale for using a non-preferred medication that is supported by the product labeling?**
   □ YES □ NO

   Please submit documentation of clinical rationale to support the use of the requested non-preferred medication.
   _____
   _____
   _____

PRESCRIBER SIGNATURE

□ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.